

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

PROVIDER CCN:  
\_\_\_\_\_

PERIOD:  
FROM: \_\_\_\_\_  
TO: \_\_\_\_\_

WORKSHEET G-2

PART I - PATIENT REVENUES

	INPATIENT					OUTPATIENT					TOTAL	
	MEDICARE FFS	MEDICARE HMO	MEDICAID	MEDICAID HMO	OTHER	MEDICARE FFS	MEDICARE HMO	MEDICAID	MEDICAID HMO	OTHER		
	1	2	3	4	5	6	7	8	9	10		
GENERAL INPATIENT ROUTINE CARE SERVICES												
1	SKILLED NURSING FACILITY											1
2	NURSING FACILITY											2
3	ICF/IID											3
4	TOTAL GENERAL INPATIENT CARE SERVICES											4
ALL OTHER SERVICES												
5	ANCILLARY SERVICES											5
6	HOME HEALTH AGENCY											6
7	AMBULANCE											7
8	HOSPICE											8
9	ALL OTHER REVENUES											9
10	TOTAL PATIENT REVENUES											10

PART II - OPERATING EXPENSES

	TOTAL												
	1												
11	OPERATING EXPENSES												11
12													12
13	TOTAL ADDITIONS												13
14													14
15	TOTAL DEDUCTIONS												15
16	TOTAL OPERATING EXPENSES												16